1973 REPORT

LEGISLATIVE RESEARCH COMMISSION

A STUDY OF EMERGENCY MEDICAL SERVICES IN NORTH CAROLINA

TO THE MEMBERS OF THE 1973 GENERAL ASSEMBLY:

The Legislative Research Commission herewith reports to the 1973 General Assembly its findings and recommendation concerning legislation for the formulation of a comprehensive emergency medical services system in the State. This report is made pursuant to Senate Resolution 827 of the 1971 General Assembly, which directed the Commission to study and investigate the problem of emergency care in North Carolina and to plan and develop "an adequate system of providing comprehensive emergency medical care throughout the State with sufficient resources to save human lives and diminish the immeasurable emotional burden and vast economic losses of avoidable disability," and to report its findings and recommendations to the 1973 General Assembly.

This study was initiated by the Emergency Medical Services Committee of the Legislative Research Commission. This Committee consisted of:

Senator F. O'Neil Jones, Chairman
Mr. Michael G. Allen
Representative E. Lawrence Davis
Representative Robert L. Farmer
Senator J. Ollie Harris
Senator John T. Henley
Representative Thomas B. Hunter
Dr. George Johnson
Mr. John H. Ketner
Senator H. Edward Knox
Representative Robert Odell Payne
Dr. George Watson

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of the

COMMITTEE ON EMERGENCY MEDICAL SERVICES

to

THE NORTH CAROLINA LEGISLATIVE RESEARCH COMMISSION

INTRODUCTION

The North Carolina Legislative Research Commission was directed by Senate Resolution 827 to "study and investigate the occurrence of injuries and fatalities caused by accident and acute illnesses among persons in North Carolina and to formulate a comprehensive emergency care service system in the state." Accordingly, a Committee on Emergency Medical Services (EMS) was appointed and a member of the Commission, Senator F. O'Neil Jones, was named Chairman. The other Committee members included six legislators and four private citizens; among the members there were business men, lawyers, insurance executives a funeral director, a surgeon (trauma specialist), and representatives of both the North Carolina Hospital Association and the North Carolina Medical Society. The Committee received technical assistance from the State Board of Health, the North Carolina Regional Medical Program, and the North Carolina Office of Comprehensive Health Planning and staff services from the Institute of Government in the University of North Carolina at Chapel Hill.

The Committee held a series of meetings and public hearings over a period of seven months and made visits to urban and rural hospital emergency rooms and a rescue squad operation. Numerous presentations, documents and materials were presented to the Committee and are in the Commission's files. In all, there were more than twenty individuals and groups who appeared before the Committee. (A list is in the Appendix). Several Committee members made other site visits to ambulance, communications and hospital emergency operations; they also attended a southeast regional EMS conference in Atlanta sponsored in May, 1972 by the U. S. Department of Health, Education and Welfare, and one in Raleigh sponsored by the North Carolina Hospital Association and the North Carolina Regional Medical Program. The Chairman and other members have been speakers or participants in several programs or training courses related to emergency medical services.

Further intensifying the work and study of the Committee has been a large amount of both private and governmental concern about emergency services as reflected in an increasing number of news stories, special publications and governmental reports on EMS, and of course, the miracles of the war zone emergency medical system have become common knowledge.

EXTRAORDINARY INTERIM ACTIONS OF COMMITTEE

Because of all this, it became shockingly evident to the Committee that emergency medical services have been the forgotten

side of otherwise increasingly sophisticated health care in this country, but that spontaneous realization of its importance has now become widespread. (See FINDINGS.) EMS is an area of public neglect which has wasted thousands of lives and uncountable days of anguish and pain, as well as unknowable sums of economic resources. The critical problem of the "uncoordinated use of existing medical care facilities, underutilization of transportation and communications technologies, and underdevelopment of trained emergency service personnel," as identified in the Study Resolution itself, became unavoidably apparent to the Committee even before the conclusion of the series of hearings. So urgent and overdue are the actions which can be taken by State Government to avert or diminish the relentless stream of unnecessary human deaths and suffering in this State that the Committee took some extraordinary steps.

The Committee authorized the Chairman to explore the feasibility of getting State agencies to respond to the crisis identified by the Committee even before it prepared its report. The Chairman called together the Secretaries of the State Departments which are currently most concerned with various aspects of emergency medical services: Human Resources, Military and Veterans Affairs, Transportation and Administration. He presented to them the problem in terms of its immediacy and potential for correction; that is, the need for focusing, rather than scattering, State resources on the EMS problem and the missed opportunities which occur daily to decrease the

tragedy of untended or improperly attended accidents. Emerging from the discussions of this meeting was the outline of a new Office of Emergency Medical Services. The Secretaries also agreed with the Chairman that the immediate need is for a consultant to begin to effect the better coordination, utilization and development of both existing and newly available resources. By analyzing ongoing State efforts and bringing together the scattered knowledge of how to cope with a statewide situation which demands improvement, a consultant with sufficient enthusiasm, status and dexterity could fashion a plan for action. The logical place for the consultant and, later, the Office of Emergency Medical Services would be in the Department of Human Resources. Dr. Lenox Baker, Secretary of the Department, agreed in the importance of the Office being created in his Department and that the Office should have special perquisities in order to cut across departmental and intergovernmental lines.

While the creation of an Office of Emergency Medical Services by legislative mandate will be the recommendation of the Committee, it is obvious that this office can not really begin working before September, 1973; the General Assembly convenes in January, 1973, the new appropriations will not become effective until July 1, 1973, and starting up processes will take several months. Therefore, the Committee requested a meeting of the full Legislative Research Commission on July 21, 1972 to make an extraordinary proposal: that the Commission request the Governor to make arrangements for funding

by directing an official in state government to prepare a request to the North Carolina Regional Medical Program for a $20,000 grant for matching funds with approximately $10,000 from the Contingency and Emergency Fund. The Commission concurred in the value of immediate action and the Co-chairmen sent a letter to the Governor asking his support and leadership in this matter.

The Governor presented the proposal for approval by the Council of State and Contingency and Emergency funds were allocated. The North Carolina Regional Medical Program expeditiously approved the proposal and request for $20,000 grant support.

OTHER ACTIONS OF THE COMMITTEE

Aside from the measures to facilitate the immediate establishment of an interim consultant and the recommendation for a North Carolina Office of Emergency Medical Services, the Committee considered the substantial volume of material presented to it both orally and in written form and made numerous useful and informative findings about "the condition and capacity of existing resources available for supplying emergency care in the State" and the challenge ahead for the new Office "to develop a statewide system which can make use of existing resources and incorporate new resources" as directed by the Study Resolution.

Not available to the Committee early enough, but promising to be essential for the work of the interim consultant and the new Office, is a report being prepared by the Research Triangle

Institute. The report, funded by the Governor's Highway Safety Program, inventories all the ground EMS transportation services, both amublances and rescue vehicles, and communications equipment, it makes recommendations concerning projections of vehicular needs and also communications requirements.

In addition, there was another study effort going on in parallel to the work of the Committee. The Committee on Emergency Medical Care of the North Carolina Medical Society developed material useful to the Legislative Research Commission Committee. Fortunately, the Medical Society's committee was chaired by a member of the Legislative Research Commission Committee, Dr. George Watson.

The Committee was apprised of studies that have been completed in other states or are ongoing. There have been numerous studies of the use of helicopters for emergency medical services, including those done in Arizona, Philadelphia, and Ohio; all of these were summarized by Mr. Ernest Ratliff of the Institute of Government.

There is an excellent report made by a Governor's Committee in Illinois to develop the concept and plan for a statewide system of trauma centers. The North Carolina Regional Medical Program representative, Mr. John Young, presented the Committee with a round-up of the EMS activities taking place in Illinois as well as in other states. The American Hospital Association's new book on the role of the hospital in EMS was distributed to the Committee. The Director of the Yale Trauma Program described to the Committee, in his visit, the difficulties and successes of the development of a state EMS

program in Connecticut. The President of Paramed, Inc., a commercial ambulance service organization operating in several cities in southeastern states, related his private corporation's quest for better emergency transportation services throughout the southeast by means of private enterprise cooperating with local governments. Dr. George Johnson, a member of the Committee and a trauma specialist, told of the increased attention of the medical profession to this previously neglected field of work. He described the work of two new professional groups -- the American College of Emergency Physicians and the University Association for Emergency Medical Services. (A summation of these studies and presentations is available in the minutes and files of this Committee.)

The net results of these activities of the Committee are the following FINDINGS and RECOMMENDATIONS which are to be considered in the context of the Committee's recommendation for an interim consultant.

FINDINGS

1. The extent of the crisis. More Americans have died from accidents in the past 60 years than from combat wounds in all our wars. The National Safety Council in 1970 reported 11,100,000 injuries from all types of accidents and a total of $13,600,000,000 in wage losses, medical expenses and administrative insurance costs resulting from trauma. The estimated total cost of this pandemic is over twenty billion dollars annually. The Council estimates that 105,000 civilian accidental deaths occur annually; nearly half are due to motor vehicle injuries. The one-millionth traffic fatality

occurred in 1951; if the present rate continues, there will be a second million victims by 1976. Although the nation's traffic injury problem is colossal, it is estimated that only 15% of the total number of accidents involve autos. Farm accidents kill thousands; home and recreaction accident deaths are about 28,000 annually. Accidents are currently the third most common cause of death in the United States, only slightly less than cardiovascular disease and cancer. Under 40 years of age, trauma is the leading cause of death. Each year about 400,000 Americans are temporarily or permanently disabled by accidents. We are annually experiencing over 15 million significant injuries in children up through thirteen years of age and over 16,000 of these are fatal; trauma is the biggest killer in this age group with the peak incidence being from two to three years. One third of all hospital admissions (2 million per year) are the result of accidents.

One leading study of 150 accidental deaths showed that 18% could have been salvaged with better emergency services. Obviously, delays in proper resuscitation and evaluation in life-endangering injuries are crucial to survival. Injudicious or inadequate emergency management can cause unnecessary fatalities and permanent disabilities.

It is no longer necessary to continue the system based on the mad rush by an ambulance to the nearest hospital emergency room which is unprepared and unequipped and unmanned. What can be done is shown by the record of our Armed Forces EMS system in Viet Nam. With

immediate first aid applied by the corpsman at the scene, and then rapid evacuation by helicopter and stabilizing patients enroute, many more severely injured patients are living long enough to reach the appropriately equipped and prepared hospital and the mortality rate from injuries in this war is the lowest in history. (Data taken from "The Critically Injured Patient", a report of the Illinois Department of Public Health; a copy is in the Committee's file.

In North Carolina, no figures on the specific extent of death and disability due to trauma were made available to the Committee, but the 1700 traffic deaths alone are cause for alarm. Apart from the ordinary accident picture, it was estimated to the Committee that up to 1/3 of all heart attack victims could be saved if proper immediate EMS treatment were available.

2. Ambulance service in North Carolina. Ambulance service problems have been troubling communities across the State and nation for the past several years. Public expectations have been raised as the result of numerous studies, discussion by the news media, and new developments (improved medical equipment and techniques, helicopters, federal highway safety standards). On the other hand funeral directors, once the primary operators of ambulance services, have gone out of the business in many areas of the State because of new minimum wage requirements and other increasing costs.

Filling the gap created by both these occurrences has been a variety of forms of ambulance service: commercial ambulance companies, rescue squads (both paid and volunteer), hospital-based service, municipal and county-operated ambulance departments, non-profit corporations, fire departments, sheriff departments, a number of funeral directors who remain in business, and combinations of some of these forms.

Various combinations of financing have been tried as well; contracts with city or county governments to provide services for a certain dollar amount, or on a contingency subsidy, or for payment by the government for certain types or amounts of collectible bills; deficit financing of government-operated services; government payment for welfare patients; and public and private donations to rescue squads.

Authority for local government to finance rescue squad operations has existed in North Carolina since 1959 (G.S. 160-191.11). Authority for local governments to provide or support ambulance service existed by implication but not until 1967 was there general legislation [G.S. 153-9(58)] enabling communities to deal adequately with the matter.

Each community has approached its particular problems in its own way, although there has been some sharing of experiences and consultants. A common problem to both government and non-government operations has been the inability to collect payment for services.

Some have developed satisfactory procedures; most have not. The commercial service in Charlotte has probably the best collection rate in the State. This may be due to the more extensive experience of the ambulance company there in developing workable business techniques, the adoption and utilization of a bill-collection ordinance, and education of the citizenry. To alleviate this common problem, in the 1967 state law a criminal penalty was prescribed for making false ambulance calls and 1969 legislation provides for liens for unpaid ambulance bills and in 42 counties garnishment and attachment proceedings.

The 1967 law directed the State Board of Health to set and enforce standards for ambulance attendants and vehicles upon the advice of an Advisory Committee (G.S. 130-230 through 130-235). The Board has issued regulations and is using local health department sanitarians for enforcement.

The 1967 law expressly authorized local governments to provide financial assistance for ambulance services and to regulate their operation. Boards of county commissioners (and/or city councils under certain conditions) may spend either non-tax funds or proceeds from a special tax levied "at such rate as may be necessary." Such expenditures are declared to be a special purpose and a "necessary expense" not subject to a vote of the people. While the North Carolina Supreme Court has not ruled on this question, the language of Moody v. Transylvania County [271 N.C. 384, 156 S.E. 2d 716 (1967)]

indicates that a referendum should probably be held if tax funds are to be used for financing ambulance operations. Nevertheless, local governments are empowered to spend available funds as necessary to "assure adequate and continuing ambulance services." They are authorized to provide (and make reasonable charges for) ambulance services or to contract with any public or private organization for such services.

In addition to the financing powers, authority is given for adopting local regulations for franchising, limiting the number of ambulances, setting reasonable rate schedules, requiring minimum indemnity provisions (but Whaley v. Lenoir County, 5 N.C. App. 319 (1969), says these requirements must be flexible), and "other necessary regulations not inconsistent with" State Board of Health regulations.

The General Assembly in 1967 declared as a matter of policy that the State has a particular interest in the provision of ambulance services (N.C. Sess. Laws 1967, Ch. 343):

> Section 1. It is hereby declared as a matter of State policy:
>
> (1) That, in order to preserve, protect, and and promote the public health, safety, and general welfare, adequate and continuing ambulance services should be available to every citizen of North Carolina.
>
> (2) That uniform minimum standards of adequacy should be prescribed and enforced by and through appropriate State and local agencies in order to assure safe, sanitary, and competent ambulance services.
>
> (3) That, insofar as it is economically feasible, ambulance services should be provided by private enterprise.

(4) That, upon the failure of private enterprise to provide adequate and continuing ambulance services in any county, the board of county commissioners of such county should be authorized to provide, or cause to be provided within said county, such services.

It is clear that the General Assembly in 1967 meant for responsibility to rest with each community to determine the best arrangement for emergency transportation services and that it delegated sufficient authority for local government to take any necessary action.

Now, however, it is just as clear to the Committee that emergency transportation services are not solely a matter for local government determination. From testimony given the Committee, there is a wide variation in the availability of ambulance services but even more apparent, a wide range of quality and competence. (There is probably an equally broad range of effectiveness in the carrying out of ambulance equipment and sanitation inspections by the inspecting sanitarians of local health departments.) One of the best governmental ambulance services in the State, and perhaps in the country, is available if an accident occurs in Guilford County. The Director of that county-operated service explained to the committee how Guilford achieved this level through personal initiative and several hundred thousand dollars of county funds. Now the crews are highly trained and proud of their work; the vehicles exceed State and national standards; the sophisticated modern business and scientific techniques are employed for control and dispatching including a computer and tape system. There are other commendable ambulance operations scattered

across the State. But strikingly there are counties nearby Guilford and the other showplaces which are woefully inadequate despite in some cases noteworthy efforts by individuals to bring ambulance services up to standards. It is difficult not to praise the many hardworking and dedicated organizers of voluntary rescue squads in areas where there previously had been no service. It is gratifying to see some counties, such as Granville, making the best out of the resources available to commit to ambulance operations.

Nevertheless, the Committee finds that ambulance services are unacceptably inconsistent and inadequate as a traveler moves across or through North Carolina. This is unfair not only to travelers, but especially to residents of the area. While not every area of the State can (or perhaps even should) have the top level of services available to many urban residents (who generally are willing to be taxed more for urban services), every citizen should have at least adequate lifesaving and trauma-handling services swiftly respond to his emergency medical crisis when it arises. This means that the State must insure this modicum of protection, where local government cannot or will not do so. How the State achieves a minimum satisfactory EMS level in every part of this vast State is a challenge for the North Carolina Office of Emergency Medical Services. But North Carolina residents deserve no less.

3. Communications. Vital to any system of several component parts is communications; with the complexities of an EMS system, it is the sine qua non for making worthwhile the expenditure of funds on

any one component. In other words, if the best equipped ambulance arrives unannounced at the emergency room door and the hospital is unprepared for the arrival, the system has broken down and patients can be lost because of it. There must be good reliable communications between the person reporting the accident, the dispatcher of the appropriate vehicle and personnel, the police and fire departments (when called for), the hospital emergency department, the medical specialists available to the hospital, and those bigger hospitals (trauma centers)to which the patient might in some cases be sent directly. There needs to be a way the State can insure that compatible equipment is installed and competent operators on duty. There needs to be a dedicated radio channel solely for emergency medical services and all should use the same frequency (155.340 MH_z), rather than the present voluntary choice and the resultant mixing of EMS with multiple other users. The communications facilities should be environmentally secure or else breakdowns will occur when emergencies are most likely also to occur.

There is a considerable amount of communications facilities and knowledge in several State agencies (Civil Defense, State Highway Patrol, State Highway Commission, National Guard, and others) and at the local level which should be assessed for EMS capability or coordination. Additionally, both Motorola and General Electric have been installing systems in community hospitals; their expertise and

cooperation should be requested. Any system needs to be statewide and should be compatible with adjacent states.

Plans for installation of the toll free EMS number 911 in Durham were announced during the Committee's work. Somehow every telephone in the State should have this toll free number for reporting emergencies and a competent dispatcher or operator must be on the other end of the phone.

4. Training. The State Board of Health and the Community College system have made great strides in arranging and conducting first aid training courses for ambulance attendants, as a prerequisite to a certificate. Nevertheless, North Carolina is behind other states (e.g., Connecticut) in providing advanced training. The federal government's recommendation of "seventy hours of instruction plus ten or more additional hours of emergency room training" seemed to the Committee to be the necessary basic minimum rather than the present 24-hour Ambulance Attendant Course required by the State Board of Health.

In its visit to Durham, the Committee was impressed with the continuing upgrading of skills that ambulance attendants received there by being utilized in a training-service role in the Watts Hospital emergency department.

It was pointed out to the Committee that lives could be saved if more citizens were skilled in first aid. The State's Good Samaritan law (enacted in 1965 as G.S. 20-166(d)) provides legal

protection to any person who assists at the scene of a vehicular accident, but it does not facilitate the likelihood that rescuers will be competent. Only by promoting "medical self-help" training (presently sponsored by the State Board of Health) and strengthening the first aid curriculum in Drivers Education Courses can this objective begin to be achieved.

5. Ambulance attendants and emergency department personnel. One of the untapped resources for significantly upgrading the level of emergency medical care provided to accident victims is the use of returning military medics as ambulance attendants and hospital emergency department personnel. While the military medic job placement project (called MEDIHC) is underway in North Carolina, the lack of adequate pay and status will hinder EMS job placement. Somehow a professionalism must be instituted in EMS work. The Yale Trauma Program Director claimed that the single most important factor in raising both pride and performance was the promotion of the 80 hour trauma training curriculum (presented in Connecticut by Dunlap Associate and the resulting classification as an "Emergency Medical Technician - Ambulance" (complete with certificates and arm patches). There is for those who qualify a National Registry of Emergency Medical Technicians - Ambulance under the aegis of the Commission on Emergency Medical Services of the American Medical Association.

The more that ambulance attendants and emergency department personnel become interchangeable, or at least equally trained, the

more likely good care will be delivered both at the scene and in the emergency department, provided that license laws do not interfere.

It was made plain to the Committee that unless there is a certified ambulance attendant in the passenger compartment of an ambulance on an emergency run (and even on some routine runs) that the passenger's chances of survival or stabilization were lessened. The law presently requires only one certified attendant aboard, and he can be the driver. A bill to require a second person was defeated in the 1971 General Assembly (H.B. 447); economic factors apparently overrode safety considerations at that time.

6. Hospital emergency facilities. North Carolina is considerably ahead of other states in assessing the potential of hospital emergency facilities being a key factor in the improvement of emergency care services all across the state. The study of hospital emergency capabilities and geographic resources which was conducted by the North Carolina Medical Care Commission in 1970 can be the basis for a plan of action leading to an optimum situation whereby emergency patients are taken to and treated in hospitals which have facilities equal to the task. Under this plan, each hospital would assess itself and its proper role in the community and then be categorized for EMS purposes. Dispatchers would then know where to send particular types of cases, bypassing the "first aid station" of a small community hospital and directly proceeding to the specialty care available at a regional or major "trauma center".

Illinois is implementing a similar plan. The North Carolina Medical Care Commission study can be the basis for early implementation of a design for North Carolina. The three hospitals connected with medical schools could be the major trauma centers (plus perhaps Charlotte Memorial Hospital) while the categories for other hospitals would be appropriate to their capability, also avoiding duplication of facilities in a community or area.

A problem that the Committee uncovered but was unable to resolve is that of fair financial support. If the county-supported hospital in one county becomes categorized as the regional trauma hospital and residents from other counties are brought in, there is a two-fold inequity involved: the non-resident emergency patient causes a strain on the resources and services of the hospital for the other patients who will be mostly county residents, and, second, emergency patients are often non-paying patients, adding an uncollectible bill problem to the local hospital and raising its net operating costs (to be borne by the in-county tax paying residents). The statutes already provide criminal penalties for failure to pay ambulance bills, but do not help the hospital trying to collect for hospital emergency services. This problem will have to be overcome before local hospitals will be willing to serve as regional or area EMS centers.

As with ambulance services the Committee observed extremes in emergency services being provided by hospitals; some are excellent,

some are virtually unidentifiable. This is understandable since Charlotte Memorial has a constant stream of emergency department arrivals while Granville Memorial seldom see a true emergency. On the other hand, the emergency departments of most hospitals are being complicated by their steady improper use as out-patient clinics. While hospital out-patient demands are increasing due to the unavailability and inaccessability of practicing physicians, an emergency room cannot be a good trauma center if it is really an out-patient clinic. Small hospitals cannot be expected to serve both functions; therefore, the categorization plan would seem to make especially good sense to small hospitals who could then not have to worry about receiving severe trauma cases.

7. Financing. The cost of establishing a good statewide EMS vehicular, communications, personnel training and hospital services program was not calculable by the Committee. What was determined, however, is that considerable efforts and expenditures are currently being devoted to various parts of the emergency medical care system and that this money, time and manpower could be expended far more effectively and efficiently. For example, in areas where two ambulance organizations both rush to the accident scene, there is waste which either a dispatcher or a franchising regulation could eliminate. The hours and hours of idle time of ambulance attendants could be used in hospitals. The duplication of administrative EMS activity in State agencies could be at least better coordinated. In short, considerable mileage can be obtained just from the better use

of existing resources.

Additionally there are sources of funding outside of State Government which could be more vigorously pursued. The North Carolina Office of Comprehensive Health Planning furnished the Committee with a beginning list. The Committee was told the story of how Jacksonville, Florida, found many outside funding sources, because of the personal efforts of an EMS promoter (Mr. John Waters) hired by the governing body. The Committee itself learned of the possibility of special funding of the interim consultant by the North Carolina Regional Medical Program. The secret seems to be to actively look for available funding sources, particularly at the federal government level. This should be one of the first jobs for the interim counsultant and also for the North Carolina Office of Emergency Medical Services.

RECOMMENDATIONS

The findings of the Committee described above manifest a number of barriers to attainment of an adequate emergency medical service system throughout the State of North Carolina: geography, tradition, density of population (and sparsity), funding, management, attitudes, expectations, technology, and law. The legal barriers are by definition the responsibility of the law makers. Hence, special attention should be given to them by the General Assembly at this time in order to promote, and not hinder, the development of EMS projects and innovations.

1. Organization at the State level for overseeing EMS operations is at present scattered and uncoordinated. The establishment of the

interim consultant can do much to identify the present range and depth of existing State EMS efforts, but he will not be able to bring them together or improve them. The interim consultant must depend on voluntary cooperation of other agencies and organizations within the context of their existing legal constraints. Thus, there is a need to develop legislation to create an Office of Emergency Medical Services with a firm statutory base and to pull together the various scattered EMS efforts of State Government into a more effective and efficient pattern. This means the eventual consolidation of all State programs into one office; but until June 30, 1973, it means at least more coordination and information interchanged. The Committee makes no specific legislative proposal on this, but points out the responsibility of the interim consultant to develop the details of a proposal to the 1973 General Assembly which would (a) create the Office of Emergency Medical Services within the Department of Human Resources, (b) adequately fund it, (c) empower it to be the designated agency for the coordination and control of all State EMS programs, (d) enable it to pursue federal and private funding, and make allocations to both governmental and private EMS local systems, (e) provide an Emergency Medical Services Advisory Council (or Committee) composed of key representatives from various governmental and private organizations concerned with EMS: hospitals, medicine, bar, local government, and ambulance services. To avoid

duplication, the existing Advisory Committee on Ambulance Service (G.S. 130-231) could be either eliminated or its membership and title revised to reflect the new purpose of advising and assisting the new Office on all EMS policy matters, and (f) give the Office such other powers and structure as appear to be needed in order to direct more State resources into the provision and promotion of emergency medical services.

2. Organization at the local level appears to be sufficiently flexible and adequately empowered to deal with EMS problems under the existing statutes (G.S. 153-9[58]). There only needs to be some immediate prodding or persuading done on those counties which have not properly exercised their powers. In some cases the primary difficulty is the lack of money to accomplish an effective local system. The new Office of Emergency Medical Services should be empowered, however, to intervene (with funds or other means) in those areas of the State where emergency services are unsatisfactory and local government is unable to act. Also, the statute for county ambulance commissions (G.S. 153-9[58][f]) should be revised to change the title and membership to reflect concern for total EMS and consideration should be given to requiring the formation of an EMS Council in every county (or perhaps health planning area).

3. Categorization of hospitals, whereby responsibility is assigned for various levels of emergency services to be provided, can be accomplished through the existing licensing powers of the Medical Care Commission, according to the Attorney General. Because of the

sensitivity and importance of this task, however, it will be necessary for legislation to be enacted (along the lines of the Illinois statutes) to provide for hospital emergency services classification. This is properly a policy matter for the Legislature to sanction, since it sets a statewide pattern of services for its citizens.

4. Personnel development and utilization in innovative ways for emergency medical services is hampered by State licensing laws. Nurses are permitted only to perform nursing services and those medical acts which it is customary for physicians to delegate to nurses. While emergency room nurses customarily do provide a number of medical services, they are not legally protected by the "emergency doctrine" (because ER services are considered to be planned and ready rather than happenstance assistance for the injured) nor by the Good Samaritan law (which applies only at the scene of a traffic accident). Since "custom" is conservative, educational and training programs in EMS for nurses cannot ethically and legally equip nurses to perform the kind of new medical services that are increasingly needed in hospital emergency departments, despite general agreement that the ER nurse is the key person for purposes of immediate aid as well as triage (screening) functions. The Committee was informed that the Committee on the Lawful Role of Nurses is making recommendations which would enable nurses to perform more emergency medical procedures.

Another legal barrier to the better use of personnel in EMS affects paramedics and ambulance attendants. The medical license laws inhibit the level of training and parameters of function for these workers. While no actions by the Board of Medical Examiners indicate that paramedics and ambulance attendants will be prosecuted for rendering increasingly sophisticated services, the statutes do not give either legal or ethical support to the performance of medical procedures said to be within the trainable competence of ambualnce attendants: for example, cardiac emergency services (closed chest massage, electrical defibrillation, drug therapy), intubation, intavenous injections, cast application, and other medical acts. The recently enacted law for "assistants to physicians" only legalizes those graduates of approved physician's assistant training programs at Duke and Bowman Gray medical schools, under the present Rules and Regulations of the Board of Medical Examiners which sets the details for qualifications. While G.S. 90-18(1 is broad enough to include ambulance and EMS attendants, it will be necessary for the Board to revise its Rules to accomplish this equalization. In the meantime, there are experimental projects going on anyway (both in North Carolina and other states) in which ambulance attendants are being used to provide emergency coronary services at the scene or in the ambulance by means of remote physician supervision and special telemetry, prior to the arrival in the hospital emergency department. The Committee requests that the effectiveness of these

programs be made known to the Board of Medical Examiners so that appropriate Rules changes will be made to promote these programs.

5. The training level of ambulance attendants is determined by rules and regulations of the State Board of Health (G.S. 130-233). Now the level is embarrassingly minimal for a certificate; only the advanced 24-hour Red Cross first aid course. To have adequately trained ambulance personnel, the U. S. Department of Health, Education and Welfare recommends a minimum "basic training of at least seventy hours of instruction, plus ten or more additional hours of emergency room training." So does this Committee. This level is provided by the curriculum for Emergency Medical Technician-Ambulance (EMT-A) and has been achieved by only a few personnel in North Carolina. A change in either the Board's regulations, or by expression in the statutes, should be accomplished to raise the minimum level of training.

6. The statutes (G.S. 130-233) should be revised to require that on every emergency run a certified ambulance attendant must be in the passenger compartment and that another person shall drive the ambulance.

NOTE: These RECOMMENDATIONS are not intended to be comprehensive and complete. They are representative of the matters that the new interim consultant should develop in detail for presentation to the 1973 General Assembly, based on the work and FINDINGS of this Committee.

Appendix A

Senate Resolution 827 of the 1971 General Assembly which Directed the Legislative Research Commission to Study the Problem of Emergency Care in North Carolina.

GENERAL ASSEMBLY OF NORTH CAROLINA
1971 SESSION

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I

SENATE RESOLUTION 827

(Public)

Sponsors: Senator Jones.

Referred to: Public Health.

June 21

A RESOLUTION AUTHORIZING AND DIRECTING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY AND INVESTIGATE THE OCCURRENCE OF INJURIES AND FATALITIES CAUSED BY ACCIDENT AND ACUTE ILLNESSES AMONG PERSONS IN NORTH CAROLINA AND TO FORMULATE A COMPREHENSIVE EMERGENCY CARE SERVICE SYSTEM IN THE STATE.

Whereas, an alarming and shocking result of the complexity of modern life is the unnecessary and senseless tragedy of human suffering, disability and death caused by uncoordinated use of existing medical care facilities, underutilization of transportation and communication technologies, and underdevelopment of trained emergency service personnel; and

Whereas, numerous efforts have been directed at various aspects of the problem across the nation and including, in North Carolina, the Cadmus-Ketner Ambulance Service Study in 1965, the General Assembly's ambulance regulation legislation in 1967, the extensive study of hospital emergency rooms by the Medical Care Commission in 1970, continuing projects by the Governor's Highway Safety Committee and many private projects and local government studies, but there is no operational comprehensive State plan for

providing and maintaining an effective and reliable system of emergency care for all persons in the State; and

Whereas, hospital emergency rooms are being flooded with both emergency and non-emergency patients (in 1969 North Carolina hospitals received 1,200,000 emergency room visits, one and one-half times the number of inpatients discharged during the same period) creating increasing demands on the limited facilities, finances and personnel in hospitals, and particularly smaller ones, at a time when availability of medical personnel in smaller communities is drastically diminishing and the advances in medical capability and technology in medical centers and the armed forces are dramatically multiplying; and

Whereas, Statewide training and licensing requirements and standards have been established by the State Board of Health for ambulance operators and vehicles, and numerous counties have met the need for emergency transportation with organization and funding but many areas of the State are inadequately served and numerous vehicles and personnel are only minimally qualified and there is no Statewide coordination of various classes of emergency services; and

Whereas, communications between and among fire and police departments, hospitals and training facilities, medical organizations and government agencies, and other essential groups are not effective to permit quick and effective response to highway accidents, home and farm accidents, poisonings, drownings, heart attacks, acute serious illnesses and other emergencies; and

Whereas, it is imperative that there be planned and developed in North Carolina an adequate system of providing comprehensive emergency medical care throughout the State with sufficient resources to save human lives and diminish the immeasurable emotional burden and vast economic losses of avoidable disability;

Now, therefore, be it resolved by the Senate:

Section 1. The Legislative Research Commission is hereby authorized and directed to study and investigate the problem of emergency care in North Carolina.

Sec. 2. It shall be the duty of the Commission to make a thorough and comprehensive study of the condition and capacity of existing resources available for supplying emergency care in this State and to plan and develop a Statewide system which can make use of existing resources and incorporate new resources so that effective and appropriate medical care and emergency services are available to people in this State. The Commission shall review and make use of studies and materials on this matter which have been prepared by governmental and private agencies. It shall examine various alternatives for regionalization, classification, regulation and provision of emergency care facilities and resources and shall take account of areas of responsibility, agreements for mutual support and modern communications systems. It shall solicit and consider ideas and proposals for improvement of accessibility (such as roadside telephones, home and business telephone stickers showing emergency numbers, universal emergency number "911," scattered mobile units), new approaches to transportation (specially

equipped helicopters, specially designed vehicles, police station wagons), new levels of training for transportation crews (comprehensive training in coronary care, intravenous injections, resuscitation), use of available and new manpower (military medic veterans, paramedical groups, fire and police personnel), new developments in communications (Statewide emergency room and vehicle voice radio, mobile video monitors, computerized records), improvement of hospital emergency rooms (classification, State financing, 24 hour services, full time physicians), changes in laws (licensing restrictions on medical teamwork and delegation of functions, highway regulations, inter-local cooperation), effective financing mechanisms (State/local support arrangements, bill collection, federal funding), and system development (State operation, regional bases, relation to other states and federal government).

Sec. 3. The departments and agencies of the State shall assist and make themselves available to the Commission as requested, and particularly the North Carolina State Board of Health, North Carolina Medical Care Commission and the Governor's Highway Safety Program.

Sec. 4. The Commission shall report its findings and recommendations to the 1973 General Assembly.

Sec. 5. This resolution shall become effective upon its ratification.

APPENDIX B

Membership of the Committee on Emergency Medical Services of the Legislative Research Commission.

COMMITTEE ON EMERGENCY MEDICAL SERVICES - MEMBERSHIP

Senator F. O'Neil Jones, Chairman
Attorney at Law
Wadesboro, North Carolina

Mr. Michael G. Allen, Vice President
McPhail, Bray, Murphy and Allen
Charlotte, North Carolina

Representative E. Lawrence Davis
Attorney at Law
Winston-Salem, North Carolina

Representative Robert L. Farmer
Attorney at Law
Raleigh, North Carolina

Senator J. Ollie Harris
Harris Funeral Home
Kings Mountain, North Carolina

Senator John T. Henley
Clinic Pharmacy
Hope Mills, North Carolina

Representative Thomas B. Hunter
Insurance Executive
Rockingham, North Carolina

Dr. George Johnson
Surgeon and Trauma Specialist
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Mr. John T. Ketner
North Carolina Hospital Association
Raleigh, North Carolina

Senator H. Edward Knox
Attorney at Law
Charlotte, North Carolina

Representative Robert Odell Payne
Distributive Education Coordinator
McLeansville, North Carolina

Dr. George Watson
North Carolina State Board of Health
Raleigh, North Carolina

APPENDIX C

List of Witnesses Who Appeard at Hearings Held by the Committee on Emergency Medical Services of the Legislative Research Commission.

WITNESSES WHO APPEARED AT HEARINGS HELD
by the

LEGISLATIVE RESEARCH COMMISSION
COMMITTEE ON EMERGENCY MEDICAL SERVICES

MR. CLIFFORD BLALOCK, Communications and Warning Officer, North Carolina Office of Civil Defense.

DR. A. B. BRADSHER, Chief of Staff, Bertie County Memorial Hospital.

MR. GENE COMBS, Administrator, Bertie County Memorial Hospital.

LT. COL. IVEY COOK, Commander of the North Carolina Wing of the Civil Air Patrol.

MR. JAMES FINISON, Director, Emergency Transportation Service, Guilford County, North Carolina.

MR. WILLIAM F. HENDERSON, Deputy Director, Department of Human Resources, formerly Executive Director of the North Carolina Medical Care Commission.

DR. MARTIN P. HINES, Director, Department of Epidemiology, State Board of Health.

MR. JAMES TILLERY, Program Director, Governor's Highway Safety Committee appeared for Mr. Elsberry Holcombe.

MR. TOM HULFISH, Para-Med, Inc., Norfolk, Virginia.

MR. ELMER JOHNSON, State Planning Division, Department of Administration.

MR. DALE JONES, Research Triangle Institute.

MR. ARTHUR K. LAMSON, Coordinator for Emergency Medical Services of the State Board of Health.

MR. W. W. LOWRANCE, North Carolina Regional Medical Program.

DR. RAYMOND MARET, Emergency Room Physician, Wake Memorial Hospital.

MR. D. KEITH PHILLIPPE, Department of Community Colleges.

MR. DUNCAN L. McGOOGAN, Hopsital Consultant, North Carolina Medical Care Commission.

LT. COL. ERWIN ROBERTS, Deputy Officer for Emergency Services, North Carolina Wing of the Civil Air Patrol.

MR. BLAIR SADLER, Yale Medical School, New Haven, Conn.

MR. HENRY SCOTT, Assistant Administrator, Wake Memorial Hospital.

MR. HOWARD SHAW, Goldsboro Commander, North Carolina Rescue Squad Association

MR. J. C. SOSSOMAN, Funeral Home Operator, Morganton, North Carolina.

MR. WILLIAM F. THOMPSON, Research Triangle Institute.

MR. JOHN YOUNG, North Carolina Regional Medical Program.

In addition to these witnesses, the Committee traveled to Durham, North Carolina and Oxford, North Carolina and talked with the following people:

Watts Hospital, Durham, North Carolina

MR. EARL POWELL, Assistant Administrator.

DR. McLAIN, Emergency Room Physician.

MISS ALENE GLASCOE, Director of Emergency Room.

MR. REECE HORTON, Durham Ambulance Service.

Granville Memorial Hospital, Oxford, North Carolina

MR. RALPH V. BOSWOOD, Hospital Administrator.

DR. J. W. WATSON, Chief of Staff.

MRS. ROPER, Director of Nurses.

MR. MORRIS PARHAM, Chairman of the Hospital Board.

MR. HENRY CURRIN, Granville County Commissioner.

DR. JOSEPH SWANTON, Staff Physician.

DR. RICHARD TAYLOR, Staff Physician.

DR. DAVID NOEL, Staff Physician.

The Chairman of the Committee also met with the following Departmental Secretaries to advise them of the Committee's plans

and hear their views concerning a Coordinator of Emergency Medical Services:

DR. JOHN LANG, JR., Secretary of the Department of Military and Veterans Affairs.

DR. LENOX BAKER, Secretary of the Department of Human Resurces.

MR. FRED MILLS, Secretary of the Department of Transportation and Highway Safety.

MR. CHARLES WILLIAMS, Assistant Director of the Department of Administration.

Appendix D

Recommended Standards for Development of Emergency Medical Systems. U. S. Department of H.E.W. Document DEHS-4, July, 1971.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration
Division of Emergency Health Services
Rockville, Maryland 20852

Recommended Standards for Development of Emergency Medical Services Systems

In response to needs at the local, State, and Federal levels, the Division of Emergency Health Services, Health Services and Mental Health Administration, in consultation with national authorities on emergency medical care, has developed the following Recommended Standards for Development of Emergency Medical Services Systems. These recommendations are not all inclusive. They treat only those areas where sufficient research substantiates the positions taken. Areas where substantive data are inadequate or nonexistent have been omitted.

The Division of Emergency Health Services recognizes that each community, State, and region has unique qualities which may make some of the Recommended Standards either nonapplicable or impossible to attain. However, it is hoped that agencies, organizations, and individuals attempting to upgrade emergency medical services will find them useful in setting goals of excellence.

AMBULANCES

1. Should meet the vehicle design specifications as recommended by the National Academy of Engineering, National Research Council. (9)

2. Should have as minimal equipment those items recommended as essential equipment by the American College of Surgeons in their May, 1970 Bulletin. (2)

3. Should exist in sufficient numbers and be so placed as to provide maximum utilization and effectiveness in the shortest possible response time.

Recommended Standards . . .

AMBULANCE PERSONNEL

1. Should have basic training of at least seventy instruction, plus ten or more additional hours of emergency room training. (1, 10A, 10B, 10C)

2. Should routinely maintain skills by observation and instruction in a hospital emergency department under the supervision of a physician, including regular critique by emergency room physicians with ambulance personnel of care administered to the patient prior to his arrival at the emergency room.

3. Should meet or exceed requirements of the National Emergency Medical Technician Registry, once established.

4. Two emergency medical technicians, one of whom may be the driver, should staff each emergency ambulance.

HOSPITAL EMERGENCY FACILITIES

1. Should promote the development of satisfactory plans for regionalization of services.

2. Should be categorized using the National Academy of Sciences' recommended criteria.

3. Should provide for ongoing self-improvement training for all emergency department staff, both clinical and administrative.

4. Should meet or exceed the emergency department standards recommended by the Joint Commission on Accreditation of Hospitals. (8, 8A, 8B)

5. Should accept a leadership role in providing training for emergency medical technicians.

6. Should base ambulance services at the hospital, wherever and whenever feasible.

COMMUNICATIONS

1. A single telephone number for emergency medical services, i.e., "911," should be instituted throughout the Nation.

2. Central dispatch should be provided for all emergency ambulances.

3. Radio or environmentally secure communications should exist between:

   a) Central dispatch center
   b) Ambulance
   c) Hospitals
   d) Law enforcement and fire units
   e) Emergency operating centers

SUPPORTIVE ACTIONS

1. Toll-free public telephone services should be available for all emergency calls from pay telephones.

2. Emergency Medical Identification should be carried by all persons with conditions or medical histories which should be known to anyone rendering emergency medical care. (3,4)

3. At least one member of every family should be trained in Medical Self-Help and/or Red Cross first aid. (11)

4. Highway signs (coordinated with hospital categorization) should be placed in adequate numbers and locations to identify emergency medical care facilities. (6)

5. Tetanus toxoid immunization should be promoted to obviate the need for administering dangerous horse serum or expensive human serum after trauma.

Important: Promotion and development of State and community Emergency Medical Services Councils (5) and EMS supporting legislation (7) are recognized by the Division of Emergency Health Services as two of the most important tools for implementing emergency medical care programs. Although these are not included in the Recommended Standards, DEHS strongly supports them.

References

1. American Academy of Orthopaedic Surgeons/Committee on Injuries: Emergency Care and Transportation of the Sick and Injured. Published by the AAOS, 430 North Michigan Ave., Chicago, Illinois 60611. 304 pp. 1971. Price $4.95.

*2. American College of Surgeons: Essential Equipment for Ambulances. Bulletin, American College of Surgeons, May 1970. A reprint.

*3. American Medical Association: Emergency Medical Identification Symbol. Published by the AMA. Two-fold leaflet. 1967.

*4. -----: Emergency Medical Identification Card. (Wallet-size carried by patients). Published by the AMA, 535 North Dearborn St., Chicago, Illinois 60610.

5. -----, Commission on Emergency Medical Services: Developing Emergency Medical Services--Guidelines for Community Councils. Published by the AMA. 1970.

References (con.)

*6. American Medical Association: Highway Directional Signs for Emergency Medical Facilities. (This 2-page leaflet reproduces (a) an AMA letter that Ernest B. Howard, M.D. sent to State and Local medical associations, et al., and (b) Illustrations of signs recommended by the AMA). March 1971. Reproduced by DEHS.

*7. -----, American Association for the Surgery of Trauma, and the National Safety Council: A Model Ordinance Regulating Ambulance Service. 10 pp. 1965. Reprinted by DEHS.

8. Joint Commission on Accreditation of Hospitals: Accreditation Manual for Hospitals. Published by the JCAP, 645 N. Michigan Ave., Chicago, Illinois 60611. 160 pp. 1971. Available as a loose-leaf binder edition for $8.00, that includes updating service through 12-31-72; or a soft-cover edition for $2.25.

*A. Hospital Emergency Services, plus interpretations. A reprint of pp. 69-76 of the ACCREDITATION MANUAL FOR HOSPITALS.

*B. Hospital Disaster Plan ... external and internal, plus interpretations. A reprint of pp. 87-90 of the ACCREDITATION MANUAL FOR HOSPITALS

#9. U.S. Department of Transportation, National Highway Bureau: Ambulance Design Criteria. (A report prepared by the National Academy of Engineering, Committee on Ambulance Design Criteria/National Research Council). Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. 57 pp. February 1970. Price 60 cents.

#10. -----: Basic Training Program for Emergency Medical Technician--Ambulance:
A - Concepts and Recommendations. 45 pp. Oct. 1969. Price 35 cents

B - Course Guide and Course Coordinator Program. 40 pp. Oct. 1969. Price 30 cents.

C - Instructor's Lesson Plans. 257 pp. Feb. 1970. Price $2.50. (These three related publications are available from the same address shown in #9).

*11. U.S. Public Health Service, Division of Emergency Health Services and the U.S. Department of Defense: Medical Self-Help Training for You and Your Community. U.S. Government Printing Office. 32 pp. Revised 1970. PHS Publication No. 1042.

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* Single copy available free from the Division of Emergency Health Services. (See address at top of page 1).

Single copy available free from the U.S. Department of Transportation, Washington, D.C. 20591.

GPO 917.246

APPENDIX E

List of EMS Documents on File with
the Legislative Research Commission

LIST OF DOCUMENTS ON FILE WITH THE LEGISLTIVE RESEARCH COMMISSION

Cardiac Defibrillation by Ambulance Attendants
Article from The New Physician, April, 1972.

The Critically Injured Patient: Concept and Statewide Plan for Trauma Centers for the State of Illinois.

Emergency Services: The Hospital Emergency Department in an Emergency Care System. American Hospital Association.

Emergency Treatment: A Matter of Life or Death
Article from The Health Law Bulletin, Volume 87, February, 1972.

Guilford County Emergency Medical Service Plan and Specifications.

Hospital Emergency Services in North Carolina - A Study of Existing Patterns and Problems; A Recommended Approach to Attainable Improvements. The North Carolina Medical Care Commission.

Proposal for Development of a Trauma Service: North Carolina Memorial Hospital.

Provision of Emergency Transportation and Medical Services
Health Law Bulletin, August, September, 1971.

Reception and Resuscitation of Casualties in South Vietnam
The Lancet, July 1, 1972.

APPENDIX F

Letter, dated July 21, 1972, from the Co-chairmen of the Legislative Research Commission to Governor Robert W. Scott.

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

July 21, 1972

The Honorable Robert W. Scott
Governor of North Carolina
Raleigh, North Carolina

Dear Governor Scott:

The 1971 General Assembly directed the Legislative Research Commission to study the resources available for the provision of emergency medical services to the citizens of North Carolina and to plan and develop a statewide system for effective and appropriate emergency medical care. The Commission began its work on emergency medical services (EMS) in January 1972 with a committee composed of legislators and some particularly knowledgeable citizens (a hospital association representative, an emergency room physician, another physician representing the medical society, and an insurance executive), chaired by Senator F. O'Neil Jones.

After an extensive series of hearings, visits to hospitals and consideration of data, this LRC committee quickly concluded that there can be a dramatic saving of life and health of North Carolina citizens who are victims of auto accidents, heart attacks, home accidents and other emergency situations. This urgent goal can be achieved through certain immediate actions that can be taken by the state government and will lead to an effective statewide coordinated EMS system. Therefore, the Legislative Research Commission seeks your support and leadership in pursuing the following plan of action:

1. Public announcement of the cost and waste of ineffective and underdeveloped emergency medical services across North Carolina and the variable availability of trained ambulance attendants, ready ambulance vehicles, capable hospital emergency rooms and reliable communications.

2. Creation of a North Carolina Office of Emergency Medical Services within the North Carolina Department of Human Resources by means of a Governor's Executive Order which would provide the Office with the powers and privileges that only a Governor can confer. The need for public visibility and Executive endorsement is absolutely essential to the success of the new Office.

3. Making arrangements for funding of the new Office of EMS, by directing an official in state government to prepare a request to the North Carolina Regional Medical Program for a $20,000 grant for matching funds with approximately $10,000 from the Contingency and Emergency Fund.

4. Choosing a person to begin work as Director on or before September 1, 1972, who is a dynamic and competent administrator with a special aptitude for promoting individual and collective action among those persons and agencies presently engaged in various phases of emergency medical services.

5. Directing the new Office of Emergency Medical Services to carry out the following assignments on or before June 30, 1973:

N. C. Office of Emergency Medical Services (EMS)

A. Functions:

1. Develop a statewide emergency medical services plan, which shall include the following components:

a. <u>notification</u> -- development of a variety of experimental and operational means for giving notice of emergency medical situations to appropriate authorities, such as roadside telephones, universal emergency number "911", promotion of citizens' responsibility to report, etc.

b. <u>communications</u> -- development of a coordinated EMS network or system among existing and new communications facilities, including hospitals, ambulances, State Highway Patrol, State

Highway Department, Civil Defense, ham operators, etc.; development of the required use of an EMS frequency; assistance to hospitals and ambulances in acquiring appropriate equipment.

c. transportation -- upgrading of ambulance vehicle equipment and sanitation requirements (and inspection procedures); utilization of ambulance survey study being compiled by Research Triangle Institute; coordination of MAST program.

d. ambulance attendants -- upgrading of training requirements (at least to DOT standards for EMT-A ambulance attendants), promoting cooperative utilization of attendants in hospital emergency departments, increasing the compensation of attendants, facilitating the employment of returning military corpsmen, fostering specialty and training programs (cardiac and pulmonary resuscitation), promoting the professionalization of ambulance attendants, etc.

e. hospitals -- developing a regional classification system for hospital emergency services related to capabilities of personnel and facilities and tied to new legal responsibilities for acceptance, referral and continuity of care for emergency patients.

f. financing -- locating fund sources for each aspect of EMS plan development; providing assistance to local efforts at developing resources; preparing a budget for State appropriations.

g. organization -- proposing and establishing an optional arrangement of existing and new governmental powers and responsibilities within a central state EMS office, including the consolidation of present agencies, personnel, budgets and programs.

h. legislation -- identifying specific needs for legislative action and preparing a proposed legislative program for implementation of the statewide plan.

2. Identify and pursue immediate federal and private funding sources for both state and local EMS projects.

3. Identify and assess all existing state agency powers and responsibilities with regard to EMS.

4. Develop demonstration programs for promotion of EMS public awareness, for integration of available knowledge into ongoing state training and education programs, and for coordination of public and private EMS efforts which are now scattered and isolated.

5. Make recommendations for legislative and administrative consideration, including the legislative establishment of an Office of Emergency Medical Services responsible to the Secretary of the Department of Human Resources.

B. Organization:

1. Location -- administratively created Office of Emergency Medical Services within the Department of Human Resources.

2. Staff -- an experienced, dynamic, and competent administrator/promoter with a secretary.

3. EMS Task Force -- a select group of representatives from the ongoing state offices responsible for various aspects of EMS programs, including State Board of Health's Epidemiology Division (ambulance certification), Personal Health Division (medical self-help training), and Medical Examiner Division (death certification); Medical Care Commission (hospital licensure); Department of Public Instruction (driver education); Highway Safety Program; State Highway Patrol; Civil Defense; and others.

4. EMS Citizens Advisory Committee -- a small, dedicated working group composed of key representatives from hospitals,

medicine, bar, local government, and ambulance organizations.

Your support and participation is the key factor in this critical and bold move to begin a new and concerted attack on the senseless loss of human lives and the immeasurable burden and vast economic losses of avoidable disability due to the lack of a coordinated, effective statewide emergency medical system in North Carolina.

Very truly yours,

Gordon P. Allen
President Pro Tempore, Senate

Philip P. Godwin
Speaker, House of Representatives